



# Alabama Board of Medical Examiners Newsletter and Report

www.albme.org

Volume 21, Number 4

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## Increase in number of store-based health clinics prompts guidelines to promote quality and safety

*Editor's note: Because of the increasing number of medical facilities located in retail stores, the AMA publicly issued a set of principles for quality medical care in these clinics. Most of these clinics are staffed by mid-level practitioners: CRNPs and PAs. In Alabama, mid-level practitioners may not practice autonomously, but must collaborate with or be registered to a physician licensed in the state. The AMA statements are principles or guidelines and, in themselves, are not legally binding, but most of these principles are covered under the Alabama Board of Medical Examiners Rules. Following is the AMA report.*

In response to public concern with the quality of care offered by a growing number of medical clinics located in large retail chain stores, the American Medical Association (AMA) has adopted a set of nine principles to ensure store-based health clinics provide patients with optimal care.

"Patients want quick and easy access to health care services, but they shouldn't have to worry about the safety and quality of care provided in these clinics," said Rebecca J. Patchin, MD, AMA board member.

According to a Harris Interactive poll, while 78 percent of the public believes that store-based health clinics could provide a fast and easy way to receive basic medical services, 75 percent raised concerns about the quality of care these clinics provide. The vast majority of respondents were also apprehensive about staff qualifications in a clinic not run by medical doctors.

Physicians deliberating the new principles at the AMA's policy-making meeting agreed with the public's concerns, noting that intensive diagnosis and care should



not be carried out at clinics staffed by less-qualified health professionals and equipped for basic services. Physicians added that health care safety could be negatively affected if in-store clinics lead to fragmentation of patient care, inadequate follow-up and missed opportunities for preventive care of patients.

To enhance public confidence in the quality of care provided by store-based clinics, the AMA adopted the following principles to help promote their safe and effective operation.

- Store-based health clinics must have a well-defined and limited scope of clinical services, consistent with state scope of practice laws.
- Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to

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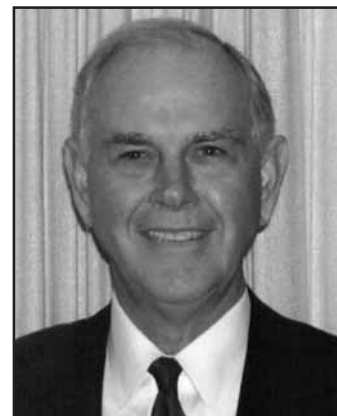
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**A Message from the Executive Director  
Prescription monitoring data base**

by Larry Dixon

The *Code of Alabama*, Section 20-2-210, et. seq., "Controlled Substances Prescription Database," states that the Alabama Department of Public Health is required to report to the statutory licensing boards every six months which of their licensees have failed to comply with the reporting requirements of the Alabama Prescription Drug Monitoring Program (PDMP).



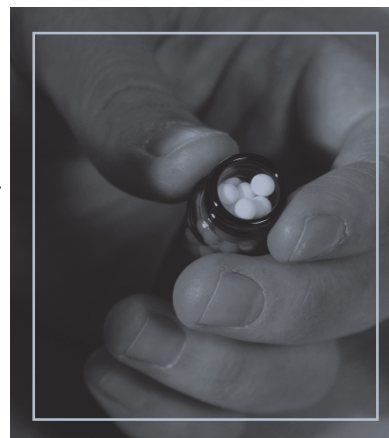
Larry Dixon

The Alabama Board of Medical Examiners has been notified by Donald E. Williamson, MD, State Health Officer, that 848 in-state registered dispensing physicians have failed to comply with state law. There are 1,119 physicians registered with the Board of Medical Examiners as dispensers of controlled substances. Of these, 1,014 physicians have failed to report any dispensing to the Alabama Prescription Drug Monitoring Program. However, a review of the 1,014 names on the list revealed 165 physicians who registered with the BME practice in other states and are not required to register as a dispensing physician or report to the PDMP. An additional physician who registered with the Board now resides in a foreign country. This means that the remaining 848 registered dispensing physicians have failed to comply with the state law. As that section of the *Code of Alabama* requires the Alabama Board of Medical Examiners to police its own registrants, failure of the dispensing physician to report to the PDMP as required by law could result in a fine being assessed.

The Board of Medical Examiners believes physicians listed as non-compliant on the report could possibly fall into several categories, which include the following:

- Physicians registered as dispensing physicians "just to be on the safe side." Apparently, this was the philosophy of some physicians who contacted this agency during PDMP advance notification, which began in late 2005.
- Physicians who only dispense legend drugs (non-controlled substances) incorrectly registered with our agency as dispensing physicians and are not required to report those legend drugs to the PDMP.
- Physicians who registered years ago as dispensing physicians and may have failed to notify us they no longer dispense controlled substances or have ceased practicing medicine.
- Physicians who properly registered with us as dispensing physicians and have dispensed controlled substances do not understand the mandatory reporting requirement in the state law.

The Alabama Board of Medical Examiners is making one final attempt to inform licensed physicians of what the law requires. This article will precede a bulk mailing to the 848 in-state physicians who have been reported as



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## Store-based health clinics

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- insure patient safety and quality of care.
- Store-based health clinics must establish arrangements by which their health care practitioners have direct access to and supervision by those with medical degrees (MD and DO) as consistent with state laws.
- Store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.
- Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
- Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as any limitation in the types of illnesses that can be diagnosed and treated.
- Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients.
- Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.

- Store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.

There are clear incentives for employers, health insurers, and retailers to participate in the implementation and operation of store-based health clinics. Employers and insurers report being able to contain health care costs by using in-store clinics, while retailers state that the clinics help increase store traffic and drive sales.

"The new AMA principles will help ensure these incentives do not override the basic obligation of store-based clinics to provide patients with quality care," said Dr. Patchin.

The Alabama Board of Medical Examiners rules that cover mid-level practitioners are available from the Board in written form on request. They may also be accessed at the Board's website, [www.albme.org](http://www.albme.org), under the Board of Medical Examiners' Administrative Rules, sections 540-X-7 and 540-X-8 and, for Physician Assistants, Sections 34-24-290 through -305 of the Alabama Code. Paraphrasing the rules relative to each principle:

- Store-based clinics must confine their activities to those allowed by state law. In Alabama this scope of practice is defined in Sections 540-

X-7 and -8 of the Alabama Board of Medical Examiners Administrative Rules.

- Treatment protocols are derived from the P.A.'s application and the Joint Committee's protocols for CRNPs. Rules require that a protocol be in place in each site remote from the practice location of the registered physician. There are further rules for medical oversight by the supervising physician in remote site clinics.
- Alabama Rules require plans and arrangements for consultation with the registered or collaborating physician and for emergency referrals for treatment.
- Except for working under the umbrella of the State Department of Public Health or under the U.S. Armed Forces, all mid-level practitioners must have an arrangement with a physician, collaboration by CRNPs and registration by PAs. Mid-level practitioners may not legally practice independently in Alabama. All medical practices must be related to a physician with an active Alabama medical license who should be responsible for ensuring the continuity of medical care.
- As previously mentioned, every medical practice staffed by a mid-

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## Prescription monitoring

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non-compliant. Each of those physician's names has been provided by the State Department of Public Health. If you are a registered dispensing physician you must comply with the law and report your dispensing of controlled substances by patient name to the Alabama Department of Public Health Prescription Drug Monitoring Program. Information regarding the report can be acquired by contacting Patti Stadleberger, RN, Prescription Drug Monitoring Program, Program Manager, PO Box 303017, Montgomery, AL 36130-3017.

The Department of Public Health notified all physicians licensed in the State of Alabama at the beginning of 2006 of the requirement, if they were a dispensing physician, and how to report to the PDMP. The Alabama Board of Medical Examiners is required to enforce this section of the law and will do so for all those dispensing physicians who are in the future determined to be non-compliant.

See the  
newsletter links  
section of  
[www.albme.org](http://www.albme.org)  
for information on  
registering and  
reporting as a  
dispensing physician.



# Communication between physicians and patients

## Some personal observations

by Arthur F. Toole III, MD, editor

In the years that I spent on the Alabama Board of Medical Examiners it was clear that a large number of complaints filed against physicians were because of poor interpersonal communication rather than medical mismanagement. The communication problems to which I refer are not the difficulty that two persons find when each has a different native language. It is the need for the speaker to make certain that the message is fully and accurately received by the listener.

I do not hold myself to be an authority on the art of communication, but I hope to stimulate

introspection about your own medical practice. Our goal as physicians is the comfort of our patients; the means to this goal is the cure, management, prevention, emotional support or other treatment of the person's disease. In this increasingly technological world it is easy to focus on the technical steps of disease management, assuming that this will produce patient satisfaction; frequently, additional care toward patient comfort is needed.

I will list some of the types of communication problems that I saw while serving on the Board and some that I have experienced myself. The list is not comprehensive

but it may generate reflection on the general issue. It is difficult to form confident patient-physician relationships without sincere, open and trusting communication.

Try to put yourself in the patient's position and answer

**your patient's questions;** have empathy. One of our greatest fears is the unknown. If the physician takes the time to explain the condition, with basic anatomical, physiological and pathological lessons in non-medical language the patient is relieved and the physician's therapy may be more efficient because of an educated patient.

Recently, I read about an Irishman, discussing communications with others, who said, "Never underestimate their intelligence, always underestimate their knowledge."<sup>1</sup> This concept is pertinent for each of us as we talk to our patients. It does not insult your patient to review fundamental and basic facts; and, the patient is often capable of grasping ideas far more complex than we may assume.

I found that using **verbal similes and visual graphics** to amplify my explanation of a complicated medical thought helped.

Verbally, I tried to use a metaphor that related to the

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*Have empathy with your patients. Explain your findings and answer their questions using words they can understand.*

*It is difficult to form confident patient-physician relationships without sincere, open and trusting communication.*

## Store-based health clinics

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- level practitioner, must have urgent and emergent referral systems.
- It is imperative that any health facility, whether store-based or not, ensure that patients clearly understand the qualification of the persons providing their health care. Not to do so puts the non-physician health care provider at risk of prosecution for impersonating a physician.
- Every medical treatment facility must ensure adequate sanitation and hygiene commensurate with the treatment given in it.
- While there is no requirement by

Alabama Code or BME Rules for a clinic to use electronic health records, because their use is becoming standardized and because such records facilitate the transfer of information, the developer of a store-based health clinic should strongly consider using EHR.

### Summary

Store-based health clinics that are staffed by mid-level medical practitioners are remote site health facilities that must comply with all Alabama Rules and Codes, including having an Alabama licensed physician responsible for the health care administered at that site.

**To read the Code of Alabama referring to this requirement, go to the newsletter links section of [www.albme.org](http://www.albme.org)**

## Communication

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patient's work or life style so that he or she could more easily grasp the concept. When trying to explain muscle fascicles, one could use the simile of orange pulp being separated by tissue into slices. While technically this is not an exact comparison, it reveals the concept.

Visually, sketches or preprinted drawings, on which you mark the pertinent information, further amplify understanding.

One of my professors told me to **choose words carefully: to comfort, not cause concern.** Many words that physicians use routinely have a different connotation in the "outside" world. Some expressions conjure discomfort: when we want some one to draw a blood sample we frequently tell the technician to "stick" the patient. When we use the words "we are going to put you to sleep" we may, especially in a child, bring the thoughts of having a pet put down; using "we are going to give you medicine to let you go to sleep like at night" may be less fearsome. With CT, MRI and other new imaging modalities we often talk of "slices;" to the non-medically informed person this sounds surgical.

Frequently, **family members** have questions about their relative's condition, treatment or prognosis. If they are not aware of important facts when they discuss your patient's illness among themselves they may make incorrect assumptions leading to incorrect conclusions. You may give information to your patient and expect the patient to relay it to the family, but, because the patient does not understand completely or forgets some of the pertinent facts, inadvertent misinformation can be spread. Logistics often prevent you and the family being present at the same time when you make rounds on your hospitalized patient. You can relate to this if you have had a confined family member. Informing the family directly or through the nurses about when you usually make rounds lets them know when to be at the bedside instead of having to wait all day or having a "hit or miss" approach to speaking with you.

**Spend quality time with your hospitalized or otherwise confined patients.** I remember many times that I was rushed on morning rounds, trying to get to surgery and very tired after a long office day during evening rounds. Regrettably, my visits with my patients sometimes

***Non-verbal communication is often as effective, and some times more so, than verbal.***

were hurried. Having had several experiences of hospitalizations for family members and for myself in the past few years, I understand how important the doctor's visit is for the patient. During the day there is time for the patient to wonder about the results of the tests that he or she has undergone and to wonder about his or her progress. The doctor's visit(s) is one of the highlights of the day. You can provide remarkable support for your patients by giving them quality time on your rounds.

When you order laboratory tests or imaging studies you have a need for the results. The patient understands this need and is anxious to learn the results as soon as possible. **Relate reports of the results of laboratory and imaging tests promptly; if there are adverse or unexpected findings provide them personally.** Contact your patient with the results promptly, either through a planned, timely follow-up appointment or by telephone. If the tests are adverse or confusing the patient appreciates hearing from the physician personally.

There are times when you discuss a patient's condition and you may sense that the patient is uncomfortable or unsure. Even if you are fully confident of your diagnosis, treatment plan, etc., **consider a consultation.** A second opinion can ease the patient's mind and such a referral may earn you the patient's respect and gratitude, leading to a better future relationship.

Many, if not most, of your patients now have Internet access. They use it as a resource for information about a diagnosis you have made or about a symptom before seeing you. We know that many sites contain erroneous information but there are reliable sites for the layperson. **Review and suggest specific Internet sites** to your patient as a place to educate themselves about their disease. One such site is [www.medlineplus.gov](http://www.medlineplus.gov); the National Library of Medicine runs it.

**Non-verbal communication counts.** You can convey a significant amount of communication with your demeanor. A ready smile, a compassionate touch, a handshake or other gesture that indicates a sincere understanding of the patient's problem creates a level of communication. Personal touching must be done carefully, especially if you are a "hugger," so that you do not fall into sexual boundary violations. There are ways that you can make physical contact with your patient without incurring these types of accusations. [Go to the newsletter links section of [www.albme.org](http://www.albme.org) to read the administrative rules addressing sexual misconduct.]

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## Board Opinions

### Ear Stapling

At its 20 December 2006 meeting the Alabama Board of Medical Examiners adopted the following opinion concerning ear stapling:

“Based upon Alabama Code §§34-24-50 and 34-24-51 and in the holding in *Williams v. State, ex. Rel. Medical Licensure Commission*, 453 So. 2d 1051 (Ala. Civ. App. 1984), it is the opinion of the Alabama Board of Medical Examiners that ear stapling for the purpose of effecting weight loss or for the purpose of treating, managing or otherwise affecting a medical condition is undertaking to treat or correct a human disease or physical condition by any means or instrumentality.

Ear stapling for the purpose of effecting weight loss or for the purpose of treating, managing or otherwise affecting a medical condition is, therefore, the practice of medicine or osteopathy, and any person who engages in the practice of ear stapling for the purpose of effecting weight loss or for the purpose of treating, managing or otherwise affecting a medical condition is engaging in the practice of medicine.

Any person who engages in the practice of ear stapling for the purpose of effecting weight loss or for the purpose of treating, managing or otherwise affecting a medical condition and who does not have a current

certificate of qualification issued by the Alabama Board of Medical Examiners and a license issued by the Medical Licensure Commission of Alabama is engaged in the unlicensed practice of medicine in Alabama in violation of Alabama Code §34-24-51.”

OPINIONS OF THE  
ALABAMA BOARD OF  
MEDICAL EXAMINERS  
can be found in the  
newsletter links section  
of [www.albme.org](http://www.albme.org).

### Communication

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**Communicate with colleagues, especially those who may be covering for you.** In current medical practice most physicians have coverage arrangements for call.

**Communicate with your colleagues who cover for you, especially about very ill or unstable patients.**

Communication with your covering physician about patients who have or may develop complex problems brings your coverage “up to speed” if an urgent problem develops.

### Summary

The essence of communication is to talk with your patients and with your colleagues. Don't be afraid of starting with the basics when explaining a medical condition or procedure. Don't assume that your patient does not have the capacity to understand a concept.

Have empathy; understand your patients' anxieties. Answer their questions until they say that they understand fully and, when appropriate, include family members in the discussion. Use common, non-medical language as much as possible to assure understanding.

**Patients worry about laboratory and imaging results. Provide them to your patient as soon as possible and answer your patient's questions.**

Realize that your patients worry about laboratory and imaging results. Provide them to the patient as soon as possible and answer the patient's questions about them. If you anticipate being out when the results arrive, make arrangement for a colleague to follow-up on them and answer questions as needed.

Remember, it is difficult to form confident patient-physician relationships without sincere, open and trusting communication.

**All of the above can be summarized with the concept of placing yourself in the position of your patient and treating your patient as you would wish to be treated if your roles were reversed.**

***“It is the patient who carries the burden of illness, but the compassionate physician shares that burden, lifting it when possible and lightening it when that is all that can be done. This sharing of the burden has always been the hallmark of the medical profession.”***

– Richard S. Hollis, MD  
*Caring: A Privilege and Our Responsibility,*  
*Obstetrics – Gynecology, 1994: 83: 1-4*



# The sagging of medical professionalism

*Editor's note: Herbert L. Fred, MD, MACP, wrote the following opinion that was printed in the Federation of State Medical Board's Journal for Medical Licensure and Discipline, volume 92, number 1, page 5. Dr. Fred is a professor in the Department of Internal Medicine, the University of Texas Health Sciences Center in Houston, Texas. He has authored several books and articles. We reprint this article with the Journal's permission.*

For the past two decades, medicine has been a profession in retreat, plagued by bureaucracy, loss of autonomy, diminished prestige and deep personal dissatisfaction.<sup>1</sup>

These ills would be bad enough by themselves. But another malady confronts us — the sagging of medical professionalism. Medical professionalism defies a precise definition.

Fundamentally, however, it boils down to service in the patient's best interest.

Among its central elements are:

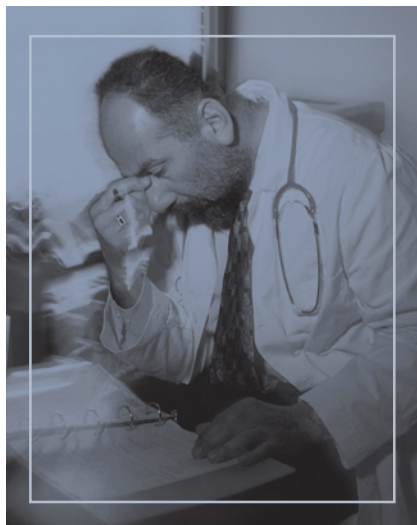
- 1) Commitment to excellence;
- 2) Altruism, with service before self interest;
- 3) Avoidance of harm
- 4) Trustworthiness;
- 5) Pursuit of truth based on scientific and humanistic criteria;
- 6) Close cooperation with others in the health care field; and
- 7) Humility.<sup>2</sup>

## Clinical manifestations and their consequences

To me, the most common, and yet most subtle, expression of betrayed professionalism is serving ourselves before serving our patients. By doing so, we sacrifice the very core of doctoring: humanism. As a result, the patient-physician bond becomes

weakened or never even forms. Additional manifestations include abuse of power, arrogance, lack of conscientiousness and conflicts of interest.<sup>3</sup>

Certain other types of behavior deserve special attention because they are sometimes interpretable as being dishonest.<sup>4</sup> Failure to take charge is a common example. In such cases, the attending physician shirks his or her responsibility, deferring to an army of



consultants, each managing a part of the body with no one managing the whole. This buck-passing<sup>5</sup> frequently leads to a host of ill-advised activities: more consultations, inappropriate testing, undocumented diagnoses, over-prescribing of medications, uncalled-for pro-

cedures, needlessly prolonged hospitalizations and unnecessary office visits. The consultants in these cases commonly shirk their responsibility as well. Although ideally positioned to halt this medical merry-go-round, they ride it instead. Moreover, those with a “gimmick” use it, even when they know it isn't indicated.

And let us not forget the fraudulent reimbursement claims to Medicaid and Medicare or those physicians who, attracted by remuneration and perhaps by a desire for public recognition, serve as expert witnesses even though they clearly are not qualified for the role.

Finally, most physicians simply remain silent when they know or suspect a colleague to be emotionally disturbed, a substance abuser or just plain incompetent. This reluctance to

get involved is particularly deplorable when they know or suspect that an associate is cheating or lying.

## Causes

Clearly, numerous factors contribute to our sagging professionalism. Heading the list, in my opinion, is a change in society's overall priorities and values. Old-fashioned hard work, devotion to duty and pursuit of excellence have taken a backseat to an emphasis on limited work hours and quests for financial and other types of personal gains. As a result, people at all levels, including many physicians, are satisfied with mediocrity. In fact, mediocrity has become the standard. Given this environment, no wonder our professionalism sags.

External forces largely beyond our control also play a role. Examples are the myriad constraints imposed by insurance companies, the incessant pressures resulting from federally mandated regulations, the glut of “for-profit-not-for-patient” hospital administrators, the lawsuits lurking around every corner and the reams of paperwork required. Attending to these various demands cuts deeply into the time we could otherwise spend attending to our patients. And complicating

*(continued on page 8)*

## References

1. Zuger, A. Dissatisfaction with medical practice. *New Engl J Med* 2004; 350:69-75.
2. Bryan CS, Brett AS, Saunders DE Jr, Khushf G, Fulton, GB. Professionalism. In: *Medical Ethics and Professionalism: A Synopsis for Students and Residents*. Center for Bioethics and Medical Humanities. University of South Carolina; 2004:13.
3. *Ibid*, p.14.
4. Fred HL, Robie P. Dishonesty in medicine. *South Med J* 1984; 77:1221-22.
5. Fred, HL. Passing the buck. *South Med J* 1982; 75:1164-65.
6. Strauss MB. *Familiar Medical Quotations*. Boston, Mass: Little, Brown and Company; 1968:374.

### BME Q & A

**QUESTION:** I anticipate retiring soon. What happens to my medical license?

**ANSWER:** When a physician retires from the active practice of medicine he or she has three options:

1. The physician can continue to maintain an active license. This requires paying the annual licensure fee and maintaining the required level of CME annually. Whether to maintain an ACSC certificate is optional; to maintain it requires paying the annual fee.
2. The physician can apply for a retirement waiver. For this, the annual CME requirement is waived, but the physician must continue to pay the annual license fee and must surrender his Alabama Controlled Substances Certificate. If the physician elects to take a retirement waiver, then decides to resume active practice at a later date, he or she must obtain a minimum of twelve hours of CME within a year before reactivating the license.
3. The physician may allow his or her license to lapse, becoming inactive by default. In this case, there is no annual fee or CME requirement. If the physician decides to return to active practice later, there is a fee of up to \$500 to reactivate the license and the physician must provide documentation of having obtained a minimum of twelve hours of recent CME. .

A fully retired physician may apply for the Retired Senior Volunteer Program (RSVP). [See the newsletter links section of [www.albme.org](http://www.albme.org) for a link to information on RSVP.] In this program the physician must meet the requirements listed in the rules. If the physician is fully retired and wishes to perform at least 100 hours of volunteer service annually at a medical facility providing medical care for no charge, he or she is granted a limited medical license with no fee. But, if the physician will prescribe controlled substances, he or she must pay the ACSC fee. The physician's RSVP license must be renewed annually and is limited to medical practice in the free clinic only.

### Professionalism continued from page 7

the picture are human frailties – especially ignorance, greed, fear of being wrong and the need for aggrandizement.

### Cures

Can we remedy our sagging professionalism? Only in so far as we are willing to be role models of integrity and honesty for each other. Only if we show commitment, compassion, competence, candor and common sense. Only if we understand and believe medicine is a calling, not a business. Only if we strive diligently to restore, preserve and promote the human element in medicine. Only if we look at, listen to and talk with our patients, working as hard and as long as it takes to ensure their welfare. Only if we always put our patients first.

### Final Thought

I leave the reader with a quotation from Béla Schick (1877-1967), renowned Hungarian pediatrician and bacteriologist:

“First, the patient, second the patient, third the patient, fourth the patient, fifth the patient and then maybe comes science. We first do everything for the patient.”

Not only do his words capture the essence of this essay, but they serve to remind us of the ruling principle of our profession!

## Do You Perform Surgery, Treatments or Examinations with any Sedation?

If so, you may be required to register with the Alabama Board of Medical Examiners and maintain specific equipment, procedures and records in your office or clinic. Check the Newsletter Links section of the Alabama Board of Medical Examiners website at [www.albme.org](http://www.albme.org) to determine whether your practice is required to register.



# Ensuring Quality in the Collaborative Practice: The 2007 Series Responsibilities and Resources for Physicians and Nurse Practitioners



A CME program presented by:  
The Medical Association of the State of Alabama  
The Alabama Board of Medical Examiners  
The Alabama Board of Nursing

## Course Details

### Who should attend?

Doctors of Medicine and Osteopathy, and Advanced Practice Nurses including Certified Registered Nurse Practitioners and Certified Nurse Midwives involved in a collaborative practice agreement.

### What will you learn?

1. The application, approval and renewal requirements for CRNP/CNMs and required credentials.
2. The responsibilities of both physicians and nurses in a collaborative practice. Common problems seen and methods to correct them.
3. The regulations for prescribing drugs, quality assurance review, remote sites and specific practice settings.

Tuition is only \$75 and includes all course materials. In addition, each attendee will receive a resource manual containing the laws governing collaborative agreements, sample forms, checklists, and QA resources!

## Course Registration Form

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Payment:  Check (made payable to MASA)       Charge      Amount \_\_\_\_\_

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Security Code \_\_\_\_\_

### Session you will attend: (check one)

- |   |                                     |    |                                     |
|---|-------------------------------------|----|-------------------------------------|
| March 29 – Birmingham<br>Cahaba Grand Conference Center - Healthsouth | <input type="checkbox"/> 1 – 4 p.m. | OR | <input type="checkbox"/> 6 – 9 p.m. |
| May 24 – Mobile, Marriott   | <input type="checkbox"/> 1 – 4 p.m. | OR | <input type="checkbox"/> 6 – 9 p.m. |
| July 26 – Decatur, Holiday Inn  | <input type="checkbox"/> 1 – 4 p.m. | OR | <input type="checkbox"/> 6 – 9 p.m. |
| August 30 – Dothan, Holiday Inn                                       | <input type="checkbox"/> 1 – 4 p.m. | OR | <input type="checkbox"/> 6 – 9 p.m. |
| November 1 – Montgomery, Montgomery Country Club                      | <input type="checkbox"/> 1 – 4 p.m. | OR | <input type="checkbox"/> 6 – 9 p.m. |

Copy this form and send to:

MASA Education Department  
19 South Jackson Street  
Montgomery, AL 36104

Phone: (334) 954-2500 • (800) 239-6272 • Fax: (334) 269-5200

## Report of Public Actions of the Medical Licensure Commission and Board of Medical Examiners

### Medical Licensure Commission August 2006

- ◆ On Aug. 25, the Commission entered an Order reprimanding the license to practice medicine in Alabama of **Dost M. Khattak, MD**, license number MD.9080, Huntsville, AL, assessing an administrative fine, and placing the license on probation subject to certain terms and conditions.

### Board of Medical Examiners August 2006

- ◆ On Aug. 19, the Board entered an Order denying the application for reinstatement of certificate of qualification of **Kenneth Norman Shannon, MD**, license number MD.10835, Montgomery, AL.

### Medical Licensure Commission September 2006

- ◆ On Sept. 11, the Commission entered an Order issuing a license to practice medicine in Alabama, limited to participation in the LSU/Ochsner Ophthalmology Residency Program, of **John P. Eitzen, MD**, license number MD.13382, Birmingham, AL.

### Board of Medical Examiners September 2006

- ◆ On Sept. 20, the Board entered an Agreed Order which revoked the license to practice as a physician assistant in Alabama of **David R. Lowery, PA**, license number PA.36, Birmingham, AL.

### Medical Licensure Commission October 2006

- ◆ On Oct. 2, the Commission entered an Order reinstating the license to practice medicine in Alabama of **Richard A. Klimas, MD**, license number MD.12803, Huntsville, AL, subject to certain conditions.
- ◆ On Oct. 2, the Commission entered an Order reinstating the license to practice medicine in Alabama of **Mark Peter Koch, DO**, license number DO.322, Houston, AL, subject to certain conditions.
- ◆ On Oct. 2, the Commission entered an Order reprimanding the license to practice medicine in Alabama of **Leon N. Davis, Jr., MD**, license number MD.16726, Montgomery, AL, and assessing an administrative fine.

- ◆ On Oct. 25, the Commission entered an Order summarily suspending the license to practice medicine in Alabama of **Joe G. Cromeans, MD**, license number MD.434, Scottsboro, AL, until such time as the Administrative Complaint of the Board shall be heard and a decision rendered thereon.

### Board of Medical Examiners October 2006

- ◆ On Oct. 18, the Board accepted the voluntary surrender of prescribing privileges in Schedules II, IIN, III and IIIN of **Rebecca Hicks, MD**, ACSC number ACSC.14402, Scottsboro, AL, effective October 10, 2006.

*(continued on page 11)*

## BME Q & A

**QUESTION:** "I have patients who, when in another state, realize that they have left their medicine at home or need a refill of a regularly taken medicine. Sometimes a patient will become ill while away from home and ask me to call in a prescription. What can I legally and ethically do when these situations arise?"

**ANSWER:** We are aware no Federal restrictions that would preclude a pharmacist in another state from accepting a legitimate prescription (written or by telephone) from a physician in Alabama who has issued that prescription in the routine course of providing that patient's care.

Each state has its own laws and it is possible a state may restrict pharmacists in that state from accepting out of state prescriptions; we are not aware of any states where this is the case. If there are restrictions, they most likely are directed at controlled substances, especially those in Schedule II.

It is not uncommon for Alabama patients to be referred to major medical clinics and institutions outside the state, such as the Mayo Clinic. These patients frequently return to Alabama to fill prescriptions written outside Alabama, without problems.

*— Ed Munson, ALBME Investigator*

**The general requirement is that the pharmacist in another state has a responsibility to confirm that the prescription, or call-in, is the product of the out-of-state physician and that the physician is appropriately licensed in the state where the prescription originated.**

## Public Action Reports of the Medical Licensure Commission and Board of Medical Examiners

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### Medical Licensure Commission November 2006

- ◆ On Nov. 15, the Commission entered an Order summarily suspending the license to practice medicine in Alabama of **Robert A. Hillman, Jr., MD**, license number MD.6898, Dothan, AL, until such time as the Administrative Complaint filed by the Board may be heard and a decision rendered thereon.
- ◆ On Nov. 22, the Commission entered an Order suspending the license to practice medicine in Alabama of **Joel C. Bolen, MD**, license number MD.20157, Montgomery, AL, such suspension, however, was immediately stayed pending completion of certain continuing medical education and payment of an administrative fine.

Should he fail to comply with the requirements within six months, the stay shall be removed and the suspension imposed.

- ◆ On Nov. 30, the Commission entered an Order denying the application for a license to practice medicine in Alabama of **Scott Joseph Waguespack, MD**, Richmond Hill, GA.

### Board of Medical Examiners November 2006

- ◆ On Nov. 18, the Board entered an Order denying the application for reinstatement of certificate of qualification of **Subu Dubey, MD**, license number MD.17831, Endicott NY.

### Correction

It was previously reported that on Aug. 4, 2006, the Commission entered an Order assessing an administrative fine against **John Rice Moody, MD**, License No. MD.15098, Huntsville, AL, for failure to meet continuing medical education requirements. That Order has been withdrawn and a new Order has been issued. The new Order finds that Dr. Moody did obtain more than 12 hours of Category 1 continuing medical education during the relevant period. However, Dr. Moody did not have documentation of all of the CME credits because one of the CME providers had failed to provide Dr. Moody with the certification. Dr. Moody was unaware of that fact at the time that he submitted his renewal application and only became aware of such fact when he was requested to submit proof to the Board.

## Upcoming CME Opportunities

### Have a Plan for Your Required CME in 2007

Avoid looking for last minute CME at the time of your license renewal. The Board of Medical Examiners, the Medical Association of the State of Alabama, many hospitals and many specialty societies sponsor programs that qualify for CME. Some upcoming CME events are:

- ◆ **Ensuring Quality in the Collaborative Practice: The 2007 Series Responsibilities and Resources for Physicians and Nurse Practitioners**
  - March 29 – Birmingham
  - May 24 – Mobile
  - June 29 – Huntsville
  - July 26 – Decatur
  - August 30 – Dothan
  - November 1 – MontgomeryContact MASA's Education Department at (334) 954-2500 or (800) 239-6272.
- ◆ **Alabama District Branch, American Psychiatric Society meeting**
  - March 29 - April 1Contact Judy Lovelady at (334) 954-2579 or (800) 318-7493
- ◆ **Medical Association of the State of Alabama Annual Session – Value: Be Strong; Be Well, Be Worth.**
  - April 12-15, Wynfrey Hotel, BirminghamContact MASA's Education Department at (334) 954-2500 or (800) 239-6272.
- ◆ **Alabama Chapter, American College of Surgeons Annual Conference**
  - April 12-14, BirminghamContact John Hooten at [jh@surgicalassociates.com](mailto:jh@surgicalassociates.com)
- ◆ **Alabama Chapter, American Academy of Pediatrics**
  - April 26-29, Sandestin, Fla.<http://alchapaap.org>





Alabama State Board of Medical Examiners

*Newsletter and Report*

Alabama Board of Medical Examiners  
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*Look inside for  
important news  
from the  
Board of Medical Examiners  
that pertains to your license  
to practice medicine  
in Alabama.*

## Change of Address

The code of the state of Alabama requires that every licensed physician notify the Board of Medical Examiners in writing within 15 days of a change of the physician's practice location address and/or mailing address.